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Issue Date: 26 May 2005

In the Matter of

DONALD R. HENLEY
Claimant

Case No.: 2004 BLA 5607

v.

COWIN AND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Joseph E. Wolfe, Attorney
For the Claimant

Ms. Mary Lou Smith, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS

This matter involves a claim filed by Mr. Donald Henley for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim

Initial Adjudication

On July 23, 1993, Mr. Henley filed his first claim for disability benefits under the Black Lung Benefits Act ("Act") (DX 1-1).[1] After extensive medical evaluations, biopsy studies, conflicting chest x-ray interpretations and medical opinions, a representative of the District Director, U.S. Department of Labor ("DOL"), determined on May 23, 1994 that the preponderance of the medical evidence indicated Mr. Henley had pulmonary sarcoidosis, rather than pneumoconiosis, unrelated to his coal mine employment (DX 1-39). On June 20, 1994, through counsel, Mr. Henley appealed the decision and requested a hearing with the Office of Administrative Law Judges ("OALJ") (DX 1-42). The District Director forwarded the case on September 29, 1994 (DX 1-43)

First Administrative Law Judge Decision and Order

Eventually, on July 10, 1996, after a couple of continuances, Administrative Law Judge Christine McKenna conducted a hearing. On September 4, 1996, Judge McKenna determined Cowin and Company ("Cowin") was not the responsible operator and denied Mr. Henley's claim. Because Mr. Henley did not fall within the Act's definition of coal miner when he worked for Cowin, the company was not a responsible operator. Concerning the presence of pneumoconiosis, Judge McKenna concluded the radiographic, CT scan and biopsy evidence was inconclusive. However, the more probative medical opinion established that Mr. Henley had sarcoidosis unrelated to coal mine employment. Judge McKenna determined that Mr. Henley established total respiratory disability. On September 25, 1996, Mr. Henley appealed the denial of his claim.

First Benefits Review Board Decision

On September 29, 1997, the Benefits Review Board ("BRB" or "Board") reversed Judge McKenna's responsible operator determination. Finding Mr. Henley's work qualified as coal mine employment, the Board reinstated Cowin as the responsible operator. Next, after affirming Judge McKenna's findings concerning the insufficiency of the radiographic and biopsy evidence to support a finding of pneumoconiosis, the BRB vacated her assessment concerning the medical opinion. Because some physicians indicated that coal dust exposure may aggravate Mr. Henley's pulmonary condition, the Board remanded the case for a determination on that issue.

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

For the purposes of Mr. Henley's second claim, his prior claim is contained in one exhibit, DX 1 and contains nearly a thousand pages. Within that exhibit, individual documents still retain their original Director exhibit numbers, although they are now filed under DX 1. As a result, references to the first claim will be as follows: "DX 1-15" The first number refers to the present Director exhibit number in Mr. Henley's second claim, the other number identifies the original Director exhibit number within DX 1.

The Board also affirmed Judge McKenna's finding that Mr. Henley had a totally disabling pulmonary impairment.

Second Administrative Law Judge Decision and Order

Because Judge McKenna was no longer available, Administrative Law Judge Clement J. Kichuk re-adjudicated the claim and granted benefits on April 30, 1998. Judge Kichuk noted that under the regulations, legal pneumoconiosis is any chronic pulmonary disease substantially aggravated by coal dust exposure. Upon evaluating the medical opinion, he concluded sufficient evidence existed to support a finding of legal pneumoconiosis because Mr. Henley's reactive airways disease was especially exacerbated by his exposure to coal dust. Judge Kichuk then determined that Mr. Henley had seventeen years of coal mine employment and his legal pneumoconiosis was caused by his coal mine employment. Based on the more probative medical evidence, Judge Kichuk also found Mr. Henley's legal pneumoconiosis was a substantial contributing factor in his total disability. Finally, Judge Kichuk set the date of entitlement as October 1, 1993. On May 6, 1998, Cowin appealed the award of black lung disability benefits.[2] In the meantime, in June 1998, the District Director initiated interim benefits.

Second Benefits Review Board Decision

On May 11, 1999, the Benefits Review Board vacated Judge Kichuk's award of benefits and again remanded the case. According to the BRB, Judge Kichuk applied the wrong legal standard in assessing whether Mr. Henley had legal pneumoconiosis. Deferring to the interpretation of the U.S. Department of Labor, the BRB indicated that temporary aggravation of a pulmonary condition was not legal pneumoconiosis. Instead, the regulatory definition of legal pneumoconiosis required a significant and permanent aggravation of a pre-existing pulmonary condition.

Third Administrative Law Judge Decision and Order

In his January 28, 2000 Decision and Order on Remand, Judge Kichuk denied Mr. Henley's claim for benefits. Because the medical opinion indicated that Mr. Henley's pulmonary symptoms would diminish once he was no longer exposed to coal dust, and applying the BRB-mandated legal standard, Judge Kichuk concluded the aggravation to Mr. Henley's lung condition was not permanent. Consequently, Mr. Henley did not have legal pneumoconiosis. Additionally, Judge Kichuk noted that even if Mr. Henley had legal pneumoconiosis, since the associated symptoms diminished after the coal dust exposure was removed, the pneumoconiosis was not a substantial contributing factor to this total disability. On February 23, 2000, Mr. Henley appealed Judge Kichuk's adverse decision.[3]

[2]Notably, in its June 1998 review petition, Cowin did not raise an objection to its reinstated status as the responsible operator.

[3]In its April 2000 response brief, Cowin did not raise its responsible operator designation in a cross-appeal.

Third Benefits Review Board Decision

On April 24, 2001, the Benefits Review Board affirmed Judge Kichuk's finding that Mr. Henley did not have legal pneumoconiosis and his total disability was not caused by pneumoconiosis. The Board observed that while medical opinion indicated that Mr. Henley's sarcoidosis was aggravated by exposure to coal dust, the extent of the aggravation was not permanent.

Over Payment Action

After Judge Kichuk's denial of benefits, in February 2000, DOL initiated an action to recover from Mr. Henley about $44,000 in benefits that he had received as interim payments. In December 2001, the District Director waived the recoupment action because Mr. Henley was not at fault in regards to the interim payments and he did not have the financial resources to repay the overpayment.

Second Claim

On July 15, 2002, Mr. Henley filed his second claim for disability benefits under the Act (DX 3). In October 2002, one physician diagnosed complicated pneumoconiosis and another doctor in April 2003 indicated Mr. Henley was totally disabled due to coal workers' pneumoconiosis (DX 9 and DX 10). In February 2003, another doctor stated Mr. Henley had possible coal workers' pneumoconiosis and sarcoidosis (DX 12).

In a preliminary Decision and Order, dated March 7, 2003, a representative for the District Director indicated Mr. Henley was entitled to benefits and that Cowin was the appropriate responsible operator (DX 22). Counsel for the Employer contested the preliminary determination and emphasized that the issue of coal workers' pneumoconiosis/sarcoidosis had been extensively litigated in Mr. Henley's first claim (DX 24). On September 30, 2003, the District Director denied Mr. Henley's claim on the basis that the evidence from the old claim, coupled with the evidence developed in the second claim established Mr. Henley did not have coal workers' pneumoconiosis. The District Director noted Judge Kichuk's finding that Mr. Henley had sarcoidosis, rather than pneumoconiosis, had been affirmed by the BRB in his first claim (DX 29). Through counsel, Mr. Henley appealed the adverse decision and requested a hearing with OALJ (DX 31). The District Director forwarded the case to OALJ on January 15, 2004 (DX 34).

On April 29, 2004, I received two motions from counsel for the Employer. First, Ms. Smith moved for a summary judgment because the Employer's liability is precluded by the doctrine of *res judicata* and constitutional due process. Correspondingly, Ms. Smith sought a protective order staying further discovery until the Motion for Summary Judgment was resolved. In a decision dated May 5, 2004, I issued an Order denying both of Employer's motions (ALJ II).

Pursuant to a Notice of Hearing, dated March 17, 2004 (ALJ I), I conducted a hearing for this case on June 8, 2004 in Kingsport, Tennessee, attended by Mr. Henley and Mr. Wolfe. Prior

to the hearing, on June 7, 2005, I received a letter from counsel for the Employer, waiving her appearance at the hearing but still contesting the previously identified issues (ALJ II).

Evidentiary Discussion

Prior to the hearing, the Employer's counsel submitted six chest x-ray interpretations, labeled EX 1 to EX 6. EX 3 and EX 4 were re-readings of the October 3, 2002 chest x-ray taken as part of the pulmonary examination obtained by the U.S. Department of Labor (DOL"). According to the evidentiary restrictions in 20 C.F.R. § 725.414, a party is limited to one rebuttal interpretation of a chest x-ray obtained during the DOL evaluation. In light of the evidentiary limitation and due to an objection from Claimant's counsel, I determined that only one of the two interpretations was admissible. In the absence of Employer's counsel, I had to make the selection (TR, pages 16 to 22). Since Dr. Wheeler placed a question mark in Block 2A concerning the presence of any abnormalities consistent with pneumoconiosis, thereby introducing ambiguity into his interpretation (EX 4), I concluded that it would be marked "offered, not admitted" and Dr. Scott's interpretation (EX 3) would be admitted.

The same situation occurred with EX 5 and EX 6, which appeared to have been offered as rebuttal to a February 26, 2003 film obtained during the pulmonary examination sponsored by a third party.[4] Once again, since Dr. Wheeler placed question marks in Block 2A (EX 6), I selected Dr. Scott's interpretation of the February 26, 2003 chest x-ray (EX 5) for admission, even though in this interpretation Dr. Scott also put a question mark over the finding of category C large opacity. Dr. Wheeler's interpretation, EX 6, is marked offered, not admitted.

Regarding the remaining two chest x-ray interpretations of a film, dated February 12, 2002, by Dr. Wheeler and Dr. Scott (EX 1 and EX 2), since I believed they were offered as rebuttal interpretations and consequently only one was admissible, I excluded Dr. Wheeler's determination due to the question mark in Block 2A. I deferred a decision on Dr. Scott's interpretation until I determined whether a February 12, 2002 chest x-ray evaluation was already in the record. Upon my review of the record, I found a February 12, 2002 chest x-ray interpretation contained in Mr. Henley's medical treatment records (CX 5). As a result, I now admit Dr. Scott's interpretation of that film as EX 2.

At the hearing, Mr. Wolfe noted that the Employer had not responded to discovery requests, which included requested admissions. He offered the discovery request, including the requested admissions, as CX 3. Mr. Wolfe believed the Employer's failure to respond rendered the factual statements admitted. Concerned that the pre-hearing Motion for Summary Judgment and request for protective order may have caused confusion about the discovery suspense dates and to provide counsel for Employer an opportunity to specifically respond, I declined to consider the requested responses as admissions at the hearing (TR, page 12). Post-hearing, on

[4]The February 26, 2003 x-ray was taken as part of an evaluation completed by Jim Walter Resources, Inc. Employer had previously objected to the inclusion of that evidence since Jim Walter Resources, Inc. is no longer a party. I overruled that objection and admitted the medical evidence (TR, page 19). *See York v. Benefits Review Board,* 819 F.2d 134 (6th Cir. 1987) (administrative law judge properly admitted evidence obtained by an adverse party who was dismissed prior to the hearing).

June 15, 2004, I issued an order providing the Employer an opportunity to respond to Claimant's requested admissions no later than July 7, 2004 (ALJ VI). On June 17, 2004, I received from Employer's counsel responses to the requested admissions, which included specific denials to the requested admissions. On July 6, 2005, Mr. Wolfe again objected to my hearing determination to give the Employer's counsel an opportunity to respond to his request for admissions. Again, in light of the unusual procedural developments in this case prior to the hearing, I find a sufficient basis existed to give the Employer's counsel a chance to respond. Consequently, Mr. Wolfe's objection is again overruled and I accept the Employer's denials to the requested admissions. Mr. Wolfe's discovery request, with the Employer's responses, is admitted into evidence at CX 3.

In light of the above comments, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 34, CX 1 to CX 5, and EX 2, EX 3 and EX 5.

ISSUES

1. Responsible operator.

2. Whether, in filing a subsequent claim on July 15, 2002, Mr. Henley has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the affirmed denial of his prior claim was based in January 2000.

3. If Mr. Henley establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on October 28, 1950, Mr. Henley married Mrs. Charlotte Henley on October 27, 1973; they currently live together. He first worked in the coal mines in 1975 and continued until his last coal mine employment in 1993, totaling 18 years of coal mine employment. Mr. Henley stopped mining coal when a doctor told him he could no longer work in the mines. In his last position as a coal miner, Mr. Henley worked underground as a miner driller, sinking a ventilation shaft and building brattices. This job required him to drill from the top of the mine to the bottom through hard rock and coal seams. He also occasionally shoveled the beltline, operated equipment, roof bolted and did other tasks except run the miner. Mr. Henley's regular work required him to lift jacks weighing 150 to 200 pounds (DX 1, DX 3, DX 7 and TR, pages 27 to 42).

Mr. Henley began experiencing breathing problems in 1992 and Dr. Cherry diagnosed black lung disease in 1994. Presently, he is unable to do any physical work and cannot carry 50 pounds. Mr. Henley is treated for his breathing problems with breathing pills and inhalers in

addition to using a breathing machine. Mr. Henley has never smoked. Mr. Henley has not been gainfully employed since he left the coal mines in 1993 (TR, pages 42 to 46, DX 1).

Issue # 1 – Responsible Operator

Cowin and Co., Inc. ("Cowin") challenges its designation as the responsible operator because it is a construction contractor, not an actual mining company and believes that Mr. Henley did not engage in the work of a "miner" within the meaning of the Black Lung Benefits Act, 30 U.S.C. § 902(d). This issue was litigated during Mr. Henley's initial claim, at which time Administrative Law Judge Christine McKenna dismissed Cowin as the responsible operator. However, upon appeal, the BRB reversed the dismissal and reinstated Cowin as the responsible operator on September 29, 1997. Counsel for Claimant objected to the re-litigation of the responsible operator issue since Cowin did not appeal its designation as responsible operator after the BRB named it as such in its May 1997 decision (ALJ V). However, because this claim is a subsequent claim, the findings from Mr. Henley's first claim may be contested by the Employer since it was not an aggrieved party based on the ultimate denial of Mr. Henley's first claim. *See Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997).

Under the regulations applicable to this claim, liability for benefits under the Act is assessed against the most recent coal mine operator which meets the requirements set out in 20 C.F.R. §§ 725.492 and 725.493. As a result, in naming a responsible operator, DOL will start with the most recent employer and work backwards in time until it finds the first operator that meets the regulatory requirements. *See Director, OWCP v. Trace Fork Coal Co., [Matney]*, 67 F.3d 503 (4th Cir. 1995) *rev'g in part sub. nom., Matney v Trace Fork Coal Co.*, 17 B.L.R. 1-145 (1993). One of the regulation provisions, which set out the numerous criteria for the designation of the responsible operator, establishes that the necessary length of employment is a cumulative period of employment for more than one year. 20 C.F.R. § 725.493 (a) (1).

Because Mr. Henley worked for Cowin from May 11, 1992 to July 28, 1993, Cowin is the most recent employer to employ Mr. Henley for more than the requisite one year length of employment. Cowin does not contest the length of Mr. Henley's employment with the company.

Instead, Cowin asserts that his employment with Cowin did not qualify him as a "miner" under the regulations. Consequently, since Mr. Henley did not engage in coal mining, Cowin cannot be designated as the responsible operator. As discussed by the BRB in its September 20, 1997 decision, to determine whether an employer is a responsible operator there is a regulatory presumption that during the course of an individual's employment with an employer, such individual was regularly and continuously exposed to coal dust during the course of such employment, which may be rebutted if the employer can establish the absence of significant periods of dust exposure "i.e. the frequency of such exposure must be so slight as to preclude its contribution to the development of a dust related disease." *Henley v. Cowin & Co.*, BRB No. 96-1770 (citing 20 C.F.R. § 725.492 (c)[5]); *Garrett v. Cowin & Co., Inc.*, 16 B.L.R. 1-77 (1990); *see also Rickard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984)). In the case before me, Cowin has not submitted any evidence to rebut its designation as the responsible operator or any applicable presumption

[5]The same provision is present in the new regulations applicable to this claim at 20 C.F.R. § 725.491 (d)

Considering the specifics of Mr. Henley's employment, I note that he spent most of his time sinking a ventilation shaft down to a mine eighteen hundred feet below the surface to where coal was being extracted and removed through an existing exit at the other end of the mine.[6] Mr. Henley's duties in sinking the shaft included drilling, shooting, mucking, and setting concrete forms, proceeding downward through geologic strata which consisted of small seams of coal and mostly sandstone rock. After the shaft broke through to the mine, Mr. Henley worked underground, in general construction for future mining operations as a roof bolter and block layer at the main coal seam. Throughout these operations, Mr. Henley was exposed to rock and coal dust (TR, pages 27 to 41).

According to the United States Court of Appeals for the Eleventh Circuit, in *William Bros., Inc. v. Pate*, 833 F.2d 261 (11th Cir. 1997), exposure to dust from any substance generated during the extraction or preparation of coal is covered under the Act. Any dust generated from activities related or integral to the extraction or preparation of coal which a claimant encounters during his employment is sufficient for him to be considered a "miner." *See Garrett, supra*; *George v. Williamson Shaft Contracting Co.*, 8 B.L.R. 1-91 (1985). Additionally, the regulation, 20 C.F.R.§ 725.101 (a) (19), includes within its definition of "miner" a person who works in coal mine construction. In the present case, Mr. Henley worked at a mine site where coal extraction was ongoing. Mr. Henley's activities in constructing an active coal mine ventilation shaft were necessary to the extraction of coal from that mine site. For these reasons, I conclude that Mr. Henley was a coal miner, which in turn makes Cowin the responsible operator.

Issue # 2 - Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that

[6]This coal mine was located in Alabama, within the jurisdiction of the U.S. Court of Appeals for the Eleventh Circuit (TR, pages 35 and 36).

something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[7] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[8] Third, the miner has to demonstrate he is totally disabled.[9] And fourth, the miner must prove the total disability is due to pneumoconiosis.[10]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Henley's case, his last claim was finally denied in January 2000 for failure to establish the presence of pneumoconiosis. However, since the record closed in Mr. Henley's last claim in September 1996, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since 1996 to determine whether Mr. Henley can now prove the presence of pneumoconiosis.

Presence of Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[11] The regulatory definitions include both clinical, or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[12] Clinical, or medical, pneumoconiosis includes those conditions "characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of

[7]20 C.F.R. § 718.202.

[8]20 C.F.R. § 718.203 (a).

[9]20 C.F.R. § 718.204 (b).

[10]20 C.F.R. § 718.204 (a).

[11]20 C.F.R. § 718.201 (a).

[12]20 C.F.R. § 718.201 (a) (1) and (2) (emphasis added).

the lung tissue to that deposition caused by dust exposure in coal mine employment." The definition includes a finding of anthrasilicosis, anthracosis, massive pulmonary fibrosis and silicosis or silicotuberculosis, which arise out of coal mine employment. The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[13] and medical opinion (§ 718.202 (a)(4)). Since obviously an autopsy report has not been submitted, Mr. Henley will have to rely on regulatory presumption, chest x-rays, biopsy report or medical opinion to establish the presence of pneumoconiosis.

Regulatory Presumption - Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner is suffering from a chronic dust disease of the lung "which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C…there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis…"[14] This type of large opacity is called "complicated pneumoconiosis." 20 C.F.R. §§ 718.304 (b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

All evidence relevant to whether the miner has complicated pneumoconiosis must be weighed. *Melnick v. Consolidation Coal Co.,* 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek*

[13]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[14]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

Coal Co., 7 B.L.R. 1-683 (1985). Therefore, even after the presence of large opacities have been established through one of the methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine if relevant evidence conflicts with or confirms a finding of large opacities and presumably complicated pneumoconiosis. For example, the Benefits Review Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in conjunction with CT-scan findings to determine there was sufficient evidence to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996).

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a two-step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence or other diagnostic results exist which are equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities, or their equivalent, exist.

Second, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

Existence of Large Opacities

Mr. Henley must rely on chest x-ray imaging, biopsy results or other medical tests, such as CT scans, showing the equivalent of a radiographic image, to establish the presence of large opacities. The radiographic evidence in the record is set out below.

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
Feb. 15, 2002	CX 5	Dr. Celso Ebeo	Findings consistent with marked amount of fibrosis from sarcoidosis with evidence of pulmonary fibrosis.
(same)	EX 2	Dr. Scott, BCR, B[15]	Positive for pneumoconiosis, profusion 1/1, [16] type q opacities; [17] category C large opacities present in

[15]B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[16]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he

			right mid lung and left lower lobe, "probably due to granulomatous due to TB (tuberculosis), cannot exclude large opacities due to silicosis/CWP (coal workers' pneumoconiosis)."
October 3, 2002	DX 9	Dr. Forehand, B	Positive for pneumoconiosis, profusion 1/1, type q opacities, category B large opacity of complicated pneumoconiosis; bilateral upper zone masses; (Rule out tuberculosis (TB) and malignancy).
(same)	EX 3	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion 1/1, category C large opacity; "all changes could be due to TB, unknown activity."
Feb. 26, 2003	EX 5	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion 1/1, type r/q opacities, category C large opacity; changes including upper lung masses/infiltrates "are probably due to TB, unknown activity. Cannot R/O (rule out) small component due to silicosis/CWP."
(same)	DX 12	Dr. C.J. Koren	Prominent interstitial pulmonary nodular disease "which certainly could be consistent with…coal workers' pneumoconiosis;" COPD present also.
(same)	DX 12	Dr. Ronald Cherry, B	Severe degree of soft tissue density and nodularity in both upper lobes with retraction of left hilum, consistent with pneumoconiosis and progressive massive fibrosis.
April 3, 2003	DX 10	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion 1/2, type r opacities, category C large opacity of complicated pneumoconiosis; emphysema and bullae present.
May 7, 2003	DX 12	Dr. John Richardson	Confluent densities in both mid to upper lung fields with appearance most suggestive of fibrosis; interstitial and coalescing fibrotic change predominantly in upper lobes consistent with pneumoconiosis.
November 24, 2003	CX 5	Dr. Mehta	(Positive for pneumoconiosis) No hilar lymphadenopathy, bilateral upper lobe fibrosis with some pneumonia like changes and bronchioectasis, findings consistent with sarcoidosis and/or pneumoconiosis.
Dec. 8, 2003	CX 2	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type r/q opacities, Category C large opacity of complicated pneumoconiosis; areas of coalescence present bilaterally, bilateral large opacities in both upper zones and in right mid-upper zone. These areas of progressive massive fibrosis constitute complicated CWP.

considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[17]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	CX 1	Dr. DePonte, BCR, B	Positive for pneumoconiosis, profusion 2/1, type q opacities, category C large opacity.

Of the seven chest x-rays in the record, there is no dispute in regards to five of the films. The October 3, 2002, April 3, 2003, and December 8, 2003 films are positive for the presence of a large opacity. On the other hand, the physicians who reviewed the May 7, 2003 and November 24, 2003 chest x-rays did not report the presence of a large opacity.

In the film developed on February 15, 2002, Dr. Ebeo observed "marked amount" of fibrosis but did not specify the size of the nodules or use an ILO classification. On the other hand, Dr. Scott noted a large category C opacity. Since Dr. Scott is a dual qualified radiologist, I give his interpretation greater probative weight. As a result, the February 15, 2002 chest x-ray also shows the presence of a large pulmonary opacity.

Three physicians reviewed the February 26, 2003 chest x-ray. Dr. Koren and Dr. Cherry apparently did not see a large pulmonary opacity in the film. In contrast, Dr. Scott observed a category C pulmonary opacity. Again, because Dr. Scott is a better qualified radiologist, his assessment has greater probative weight. Based on his more probative opinion, I conclude the February 26, 2003 chest shows the presence of a large category C opacity.

Since five of the seven chest x-rays (February 15, 2002, October 3, 2002, February 26, 2003, April 3, 2003, and December 8, 2003) show the presence of a large opacity, I find the preponderance of the radiographic evidence establishes the existence of large opacities. Additionally, very little evidence in the record suggests the observed opacities are not actually present. In fact, as set out in the discussion of the CT scans, other probative evidence establishes that the large opacities on the x-ray films represent actual large masses in Mr. Henley's lungs. Consequently, Mr. Henley has definitively established the presence of a large opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304 (a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

Other Medical Evidence

Since Mr. Henley has proven the existence of a large opacity, I move to the second adjudicative step and consider other relevant medical evidence prior to making a determination of whether Mr. Henley has invoked the 20 C.F.R. § 718.304 presumption. At this stage, I consider all other medical evidence to determine if it conflicts with or confirms a finding of large opacities and associated finding of complicated pneumoconiosis. In Mr. Henley's case, the "other" medical evidence has five components: A) CT scan interpretations; B) lung biopsy; C) other objective pulmonary test results D) medical opinion based on evaluation and treatment; and, E) physician x-ray comments.

A. CT Scans

Dr. Stacy Stevens
CX 5

According to Dr. Stevens, the CT scan of February 27, 2002 was consistent with changes from sarcoidosis with marked amount of pulmonary fibrosis. Dr. Stevens noted that the only portion of the lungs spared were the lung bases and most superior aspect of lung apices.

Dr. Harsha Shantha
CX 5

Dr. Shantha read the CT scan taken of Mr. Henley on March 18, 2002. The physician observed bilateral fibrotic changes in the mid-lung region and believed these findings were consistent with sarcoidosis and fibrosis.

Dr. C.J. Koren
DX 12

Dr. Koren read the CT scan taken of Mr. Henley on February 26, 2003. He observed prominent bullous lesions, some that were 3 to 4 centimeters in lower lung fields and kerley lines. Dr. Koren diagnosed interstitial disease with considerable consolidation in the mid-upper portion of lungs with surrounding nodularity.

Dr. Kelly Gunter
CX 5

Dr. Gunter read another CT scan taken of Mr. Henley on December 1, 2003 and compared it to the study from February 27, 2002. Dr. Gunter noted that since the previous exam, there had been progression of the reticular nodular pattern involving the periphery of the lungs. The perihilar masses are consistent with extensive fibrosis. The moderate increase in reticular nodular pattern was consistent with interstitial disease.

Discussion

On the issue of the presence of a fibrotic process, all four physicians observed fibrotic changes in the lung, which is consistent with pneumoconiosis. The same physicians disagree on whether sarcoidosis is also present. Dr. Shantha and Dr. Stevens found it; Dr. Koren and Dr. Gunter did not. This opinion standoff means the CT scan evidence is inconclusive on the presence of sarcoidosis. At the same time, as noted by Dr. Gunter, the only physician to compare two of the CT scan images, Mr. Henley's pulmonary fibrosis progressed over time. The February 2002 CT scan indicated a marked amount of fibrosis. By the time of the December 2003 CT scan, fibrotic changes showed a progression of the recticulonodular pattern. Thus, none of the CT scan observations represent evidence that is contrary to a finding of complicated pneumoconiosis.

B. Lung Biopsy

On January 14, 2004, Dr. David Soike, board certified in anatomic pathology and clinical pathology,[18] evaluated several tissue samples from Mr. Henley's lungs and associated lymph nodes. The largest lung tissue sample size had an aggregate size of 1.5 x 0.5 x 1 centimeters. The pulmonary lymph nodes did not contain any tumors and were anthracotic and benign. The tissue samples from the right upper lobe showed increased interstitial fibrosis with a moderate number of macrophages. In those lung tissue samples, Dr. Soike specifically highlighted the absence of any granulomas or "active fibrogenesis."

Dr. Soike's finding of anthracotic pulmonary lymph nodes and interstitial fibrosis with macrophages does not represent contrary evidence of complicated pneumoconiosis in Mr. Henley's lungs.

C. Pulmonary Test Results

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[19] post[20]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[21] pre Post**	**Comments**
CX 5	March 4, 2002 Dr. Jay Mehta	51 71.0″	1.37 1.68	2.44 2.59	45 49	56.1% 64.9%	Yes[22] Yes	Probably restrictive lung disease, obstruction possible
DX 9	October 3, 2002 Dr. Forehand	51 70.0″	1.81 2.06	3.18 3.41	47 63	56.9% 60.4%	Yes[23] Yes	Obstructive ventilatory pattern
DX 10	April 3, 2003	52	1.51	2.96	46	51.0%	Yes[24]	Mild

[18]As I informed the parties at the hearing (TR, page 8), I take judicial notice of Dr. Soike's board certification and have attached the certification documentation.

[19]Test result before administration of a bronchodilator.

[20]Test result following administration of a bronchodilator.

[21]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[22]The qualifying FEV1 number is 2.27 for age 51 and 70.9″; the corresponding qualifying FVC and MVV values are 2.86 and 91, respectively.

[23]The qualifying FEV1 number is 2.17 for age 51 and 69.7″; the corresponding qualifying FVC and MVV values are 2.74 and 87, respectively.

[24]The qualifying FEV1 number is 2.10 for age 52 and 68.9″; the corresponding qualifying FVC and MVV values are 2.64 and 84, respectively.

	Dr. Rasmussen	69.0″	1.71	3.22	62	53.1%	Yes	airway obstruction
DX 12	May 7, 2003 Dr. Cherry	52 70.98″	1.23 1.59	3.13 2.68		39.3% 59.3%	Yes[25] Yes	

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified[26]**	**Comments**
DX 10	April 3, 2002 Dr. Rasmussen	39	75	No[27]	Severe, slightly reversible restrictive and obstructive ventilatory impairment.
DX 9	October 3, 2002 Dr. Forehand	39	82	No	Valid.[28]

Discussion

The objective pulmonary test evidence demonstrates Mr. Henley has a totally disabling pulmonary impairment. All four of the pulmonary function tests meet the regulatory total disability standards. Under the provisions of 20 C.F.R. § 718.204 (c) (1), if the preponderance of the pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary test evidence shall establish a miner's total disability. To apply this regulatory section requires a five step process. First, an administrative law judge must determine whether the tests conform to the pulmonary function test procedural requirements in 20 C.F.R. § 718.103. Second, the results are compared to the qualifying values for the various tests listed in Appendix B to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19, 1-21 (1987).

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[25] The qualifying FEV1 number is 2.25 for age 52 and 70.9″; the corresponding qualifying FVC and MVV values are 2.84 and 90, respectively.

[26]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[27]For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[28]Dr. John Michos certified the test results as valid on October 29, 2002.

With these principles in mind, I first note that all of the pulmonary function studies appear to conform to regulatory standards and no physician has challenged their validity. Next, all of the tests produced results that are qualifying under the regulation to establish total disability. In terms of contrary evidence, none really appears on the newly developed record. Both Dr. Forehand and Dr. Rasmussen concluded that Mr. Henley does not retain the pulmonary capacity to return to his former coal mine employment. Thus, Mr. Henley's total disability established through qualifying pulmonary function studies does not provide contrary evidence to a diagnosis of complicated pneumoconiosis. Rather, these studies independently support a finding that Mr. Henley is totally disabled due to a pulmonary impairment which is consistent with the invoked presumption of total disability due to the presence of complicated pneumoconiosis.

Although none of Mr. Henley's arterial blood gas studies similarly establish total disability, those non-qualifying tests measure only one aspect of Mr. Henley's respiration capacity. As a result, these arterial blood gas studies neither impeach the total disability established by the pulmonary function tests nor a determination that the large opacities in Mr. Henley's lungs represents complicated pneumoconiosis.

For the reasons stated above, I find the pulmonary tests do not negate the radiographic finding of large opacities in Mr. Henley's lungs or establish some cause other than pneumoconiosis for the large opacities.

D. Medical Opinions

Dr. Randolph Forehand
DX 9

On October 3, 2002, Dr. Forehand, board certified in pediatrics, allergy and immunology,[29] conducted a pulmonary evaluation of Mr. Henley who reported productive cough, wheezing, and dyspnea. Mr. Henley has a coal mine employment history of about 19 years, 13 of which were underground. He never smoked cigarettes. In the chest x-ray, Dr. Forehand observed large opacities consistent with complicated coal workers' pneumoconiosis. The pulmonary function test revealed an obstructive ventilatory pattern and the arterial blood gas study produced normal results. Upon chest exam, Dr. Forehand observed scattered crackles heard at bases. Based on the radiographic evidence of larger opacities and Mr. Henley's coal dust exposure, Dr. Forehand diagnosed complicated pneumoconiosis. He also indicated that tuberculosis and malignancy should be ruled out. Dr. Forehand believes Mr. Henley has a significant respiratory impairment and is unable to return his last coal mine job or similar work. The physician rendered Mr. Henley totally disabled from a respiratory standpoint and opined that the coal workers' pneumoconiosis is the "sole factor" contributing to respiratory impairment.

[29]I take judicial notice of Dr. Forehand's board certification and have attached the certification documentation.

Dr. Donald Rasmussen
DX 10

On April 3, 2003, Dr. Rasmussen, board certified in internal medicine, conducted a pulmonary evaluation of Mr. Henley who reported shortness of breath with exertion over the past 10 to 12 years, significant dyspnea when climbing one flight of stairs, chronic productive cough and wheezing at night and with exertion. Mr. Henley reported a medical history of chronic bronchitis and asthma. He is a non-smoker and worked in the coal mines for 19 years. His last coal mine employment occurred in 1993.

A chest exam revealed breath sounds that were tubular in upper zones and moderately to markedly reduced in lower zones. A B-reading chest x-ray interpretation by Dr. Patel showed the presence of pneumoconiosis with category C large opacities. The pulmonary studies revealed severe, slightly reversible restrictive and obstructive ventilatory impairment and maximum breathing capacity was markedly reduced with significant improvement after bronchodilator. Mr. Henley's total lung capacity and single breath carbon monoxide are minimally reduced.

Dr. Rasmussen opined that Mr. Henley suffers a marked loss of lung function and does not retain the pulmonary capacity to perform his last regular coal mine employment with required heavy and very heavy manual labor. Mr. Henley's significant history of coal dust exposure and x-ray changes consistent with complicated pneumoconiosis lead Dr. Rasmussen to conclude that Mr. Henley has complicated pneumoconiosis from coal mine employment. His only risk factor for a totally disabling respiratory insufficiency is coal dust with resultant progressive massive fibrosis.

Dr. Ronald Cherry
Roane Medical Center
DX 12

On February 26, 2003, Dr. Cherry, board certified in internal medicine, pulmonary disease and critical care,[30] evaluated Mr. Henley's pulmonary condition. Mr. Henley complained of dyspnea with exertion after walking one to two blocks on level ground or when climbing a flight or two of stairs for the past 10 to 12 years. He also coughed and wheezed at night, suffering from a mild chronic intermittent cough as well. Mr. Henley worked in deep and surface coal mines for 18 to 19 years, ending his coal mine employment in 1993. He denies any exposure to asbestos dust and indicated that he was diagnosed with sarcoidosis in 1992. A chest exam was fairly clear to auscultation and percussion without wheezes, rales or rhonchi. Dr. Cherry diagnosed possible pneumoconiosis, "which could be related to both coal workers' pneumoconiosis and/or silicosis," possible sarcoidosis and asthma.

On May 7, 2003, Dr. Cherry conducted a follow-up evaluation of Mr. Henley. A physical exam revealed fairly clear chest although there was some prolongation of expiratory phase of respiration. Pulmonary function test results indicated severe combined obstructive and restrictive impairment, which improved after bronchodilation. A chest CT scan confirmed Dr.

[30]I take judicial notice of Dr. Cherry's board certification and have attached the certification documentation.

Cherry's findings. The physician diagnosed severe pneumoconiosis probably due to coal workers' pneumoconiosis and silicosis with development of progressive massive fibrosis, chronic asthma and a possible element of sarcoidosis. However, Dr. Cherry noted that clinically he finds a diagnosis of sarcoidosis questionable and believes that Mr. Henley's clinical symptoms and x-ray findings can be explained by his exposure to both rock dust and coal dust.

Dr. Jay Mehta and Dr. Harsha Shantha
Pulmonary Associates of East Tennessee
CX 5

In March 2001, Mr. Henley presented with episodes of dyspnea. Dr. Jay Mehta's examination of his chest proved unremarkable. The physician diagnosed sarcoidosis, occupational disease or pneumoconiosis with chronic obstructive pulmonary disease.

On February 15, 2002, Dr. Mehta again evaluated Mr. Henley who complained of shortness of breath with sputum and wheezing. A physical exam of the chest showed that it was normal. Dr. Mehta concluded that Mr. Henley had sarcoidosis, pneumoconiosis, and mild COPD/asthma.

On March 18, 2002, Dr. Harsha Shantha treated Mr. Henley. He noted Mr. Henley's medical history, which included sarcoidosis and exposure to coal mine and sand dust. He also reported that Mr. Henley had no history of cigarette smoking. Physical exam of the chest was normal. A pulmonary function test produced evidence of a combined ventilatory defect and a CT scan showed bilateral fibrotic changes in the mid-lung region. The findings reported are consistent with sarcoidosis and fibrosis. Dr. Shantha concluded that Mr. Henley's symptoms were related to a combination of sarcoidosis with a restrictive lung disease which has been stable and an obstructive component from coal workers' pneumoconiosis. Mr. Henley was being treated for his breathing problems with an inhaler and bronchodilator therapy.

On June 13, 2002, Dr. Mehta again evaluated Mr. Henley's pulmonary condition. The physician reported Mr. Henley's belief that he had been diagnosed with sarcoidosis but the physician noted that such a diagnosis had not been fully confirmed. A chest exam showed bilateral expiratory wheezing and prolonged expiratory phase. The diagnosis included COPD (chronic obstructive pulmonary disease) which could be consistent with pneumoconiosis. Radiographic evidence in the past is also consistent with pneumoconiosis and/or sarcoidosis.

On November 11, 2002, Mr. Henley's pulmonary condition was evaluated by Dr. Mehta. A physical exam of the chest showed that it was normal. The physician diagnosed black lung disease, sarcoidosis and some lung fibrosis.

On November 24, 2003, Mr. Henley reported coughing, shortness of breath and minimal wheezing during his follow-up evaluation with Dr. Mehta. The x-ray showed bilateral pulmonary infiltrates with changes consistent with pneumonia or sarcoidosis or pneumoconiosis.

On January 2, 2004, a new CT scan showed worsening interstitial process. Mr. Henley continued to report cough and shortness of breath. The results of his pulmonary function tests

were progressively worsening. Based on the CT scan, Dr. Mehta believed Mr. Henley suffers from progressive coal workers' pneumoconiosis or severe lung fibrosis from interstitial fibrosis. The chest exam revealed bilateral few basilar rales. Dr. Mehta concluded that Mr. Henley had COPD, coal workers' pneumoconiosis ("CWP"), history of sarcoidosis, progressive pulmonary fibrosis, "etiology could be CWP [versus] idiopathic pulmonary fibrosis."

Dr. Mehta reviewed the January 14, 2004 lung biopsy results and examined Mr. Henley again on January 23, 2004. The chest exam was normal. Dr. Mehta concluded that Mr. Henley "seems to have lung fibrosis." He found no clear evidence of sarcoidosis. Dr. Mehta then opined that the diagnosis should be idiopathic pulmonary fibrosis or coal workers' pneumoconiosis.

Discussion

Of the five physicians who evaluated Mr. Henley's pulmonary condition, three doctors diagnosed either complicated pneumoconiosis or progressive massive fibrosis. Dr. Forehand based his conclusion that Mr. Henley has complicated pneumoconiosis on radiographic evidence of large opacities and Mr. Henley's coal dust exposure. At the same time, Dr. Forehand suggested that malignancy and tuberculosis should be ruled out. Concerning these later two possibilities, a January 2004 lung biopsy did not produce any evidence of malignancy. Similarly, the medical record fails to establish that Mr. Henley presently has or had tuberculosis.

Similarly, Dr. Rasmussen found the radiographic evidence to be consistent with complicated pneumoconiosis, resulting from coal mine employment. Specifically, Dr. Rasmussen opined that the only risk factor Mr. Henley had is his coal dust exposure, which resulted in progressive massive fibrosis. Since Dr. Rasmussen believed that coal and rock dust were the only risk factors for Mr. Henley, he did not address any other possible diagnoses; however, his complicated pneumoconiosis diagnosis is consistent with the other objective medical evidence in the record.

Based on chest x-rays and CT scan findings, Dr. Cherry diagnosed severe pneumoconiosis probably due to coal workers' pneumoconiosis and silicosis with development of progressive massive fibrosis. This diagnosis is consistent with a finding of complicated pneumoconiosis. Notably, the Supreme Court recognized complicated pneumoconiosis as "involv[ing] progressive massive fibrosis as a complex reaction to dust and other factors." *Usery v. Turner Elkhorn Mining Co*., 428 U.S. 1, 7 (1976). Therefore, Dr. Cherry's medical opinion essentially represents a diagnosis of complicated pneumoconiosis. Dr. Cherry noted a possible diagnosis of sarcoidosis, which Mr. Henley reported in his medical history. However, the physician concluded that clinically, he believes a diagnosis of sarcoidosis is questionable. The symptoms and x-ray findings are better explained by Mr. Henley's exposure to rock and coal dust.

During his initial evaluations of Mr. Henley in early 2001 and 2002, Dr. Mehta diagnosed sarcoidosis, pneumoconiosis and mild COPD (chronic obstructive pulmonary disease)/asthma initially. By June 2002, Dr. Mehta noted that although Mr. Henley believed he had been previously diagnosed with sarcoidosis, the diagnosis was not fully confirmed. He again

diagnosed pneumoconiosis and/or sarcoidosis based on the radiographic evidence. Following a January 2004 CT scan, which indicated a worsening interstitial process, Dr. Mehta diagnosed COPD, severe lung fibrosis, history of sarcoidosis and progressive pulmonary fibrosis. Later, after reviewing a lung biopsy report, Dr. Mehta found no evidence of sarcoidosis and diagnosed idiopathic pulmonary fibrosis or coal workers' pneumoconiosis. Dr. Mehta did not specifically diagnose complicated pneumoconiosis. His most recent assessment that Mr. Henley's pneumoconiosis is progressively getting worse is not inconsistent with the presence of complicated pneumoconiosis.

Finally, upon the one occasion he treated Mr. Henley, Dr. Shantha believed Mr. Henley struggled with both sarcoidosis and coal workers' pneumoconiosis. While his dual diagnoses introduces sarcoidosis rather than pneumoconiosis as an explanation for the presence of the large opacities, his diagnosis of sarcoidosis is outweighed by the conclusions of the other four physicians who found insufficient clinical evidence to definitively diagnose sarcoidosis.

The consensus of Dr. Forehand, Dr. Rasmussen and Dr. Cherry that Mr. Henley has complicated pneumoconiosis represents the preponderance of medical opinion and outweighs the diagnoses of Dr. Mehta and Dr. Shantha to the extent they contraindicate the presence of complicated pneumoconiosis. At the same time, Dr. Mehta's assessment has significant probative value relating to the possible diagnoses of sarcoidosis, granulomas, and tumor. Over the course of his treatment of Mr. Henley's breathing problem and upon the completion of diagnostic CT scans and a lung biopsy, Dr. Mehta essentially eliminated the diagnosis of sarcoidosis and noted that the biopsy report failed to show the presence of granulomas in the lung tissue. The same biopsy did not contain any malignant tumor cells. Consequently, the preponderance of medical opinion does not impeach a finding of complicated pneumoconiosis based on radiographic images of large opacities.

E. Chest X-Ray Comments

In the comment section of his interpretations of the February 12, 2002, October 3, 2002, and February 26, 2003 chest x-rays, Dr. Scott offered the following possible etiologies for the large opacities: granulomatous due to tuberculosis, silicosis, coal workers' pneumoconiosis, and "unknown" activity. In terms of probative value, those comments have little weight in terms of contrary evidence of complicated pneumoconiosis for three reasons. First, by presenting several explanations, including an "unknown" process, Dr. Scott is basically stating that he doesn't know the cause of the large opacities. Such an equivocal position is not sufficient contrary evidence. Second, the subsequent lung biopsy and CT scans, establishing the presence of an interstitial lung disease, which Dr. Scott did not review, seem to eliminate a granulomatous process as a possible cause of the lung masses. The same tests also failed to identify any previously "unknown" process that might explain the presence of the pulmonary masses. Third, as previously mentioned, the medical record contains no evidence that Mr. Henley has ever struggled with tuberculosis.

Conclusion

If chest x-rays vividly establish the presence of large opacities as defined by the Act, the invocation of the presumption under 20 C.F.R. § 718.304 is appropriate if the other medical evidence does not establish that a) either that the large opacities are not actually present; or, b) another etiology is responsible for the presence of the masses, which is unrelated to exposure to coal dust. Upon my review of the entire medical record developed since 1996, including a lung biopsy, CT scans, objective pulmonary tests, medical opinion and chest x-ray comments, I find insufficient contrary evidence that a pathology unrelated to coal dust is the cause of Mr. Henley's large pulmonary opacities. Accordingly, I conclude Mr. Henley is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 that he is totally disabled due to pneumoconiosis through: a) the presence of large opacities in the February 15, 2002, October 3, 2002, February 26, 2003, April 3, 2003, and December 8, 2003 chest x-rays; and b) the absence of sufficient contrary medical evidence showing that large opacities are due to another cause unrelated to coal dust exposure.

Concerning the present second claim, through the invocation of the 20 C.F.R. § 718.304 presumption, Mr. Henley has proven that he has become totally disabled due to pneumoconiosis, which in turn establishes that since the denial of his prior claim Mr. Henley has developed pneumoconiosis, thereby establishing one of the conditions of entitlement that he previously failed to prove. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. Henley is entitled to black lung disability benefits.

Issue #3 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Henley must prove that he has a) pneumoconiosis b) that arose out of his coal mine employment and that he is c) totally disabled d) due to coal workers' pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. Henley must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. §718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Mr. Henley has at least 18 years of coal mine employment. As a result, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. Henley's pneumoconiosis and his coal mine employment.

As a starting position, I note that in Mr. Henley's prior claim, Judge Kichuk determined that the preponderance of the more probative medical opinion established the presence of a lung disease other than pneumoconiosis, which was not caused by coal dust exposure. Judge Kichuk

based his finding on the temporary nature of Mr. Henley's symptoms. Because Mr. Henley's symptoms diminished upon leaving the coal mine site, Mr. Henley's coal dust exposure did not cause a "significant and permanent" aggravation of his lung condition.

However, according to the regulations, 20 C.F.R. § 718.201 (c), pneumoconiosis is a latent and progressive disease, which may worsen once the miner ceases coal mine employment.[31] The more relevant medical opinion is therefore the evidence developed in Mr. Henley's second claim. As I already found, the newly submitted medical evidence establishes the permanent presence of large opacities in Mr. Henley's lungs, which has invoked the irrebuttable presumption that he had complicated pneumoconiosis. The medical opinion and evidence in his prior claim does not alter that determination.

Considering Mr. Henley's non-existent cigarette smoking history and 18 years of coal mine employment, and based on their pulmonary evaluations, both Dr. Forehand and Dr. Rasmussen specifically attribute the pneumoconiosis present in Mr. Henley's lungs to his exposure to coal dust. Dr. Mehta and Dr. Cherry were less certain and did not definitively identify coal dust as the cause of the pneumoconiosis. However, their less-than-certain conclusions about the etiology of the pneumoconiosis is insufficient to rebut the regulatory causation presumption. Although other etiologies were raised by Dr. Scott and Dr. Shantha, for the reasons previously discussed, I found those potential diagnoses insufficient to attribute the large masses in Mr. Henley's chest to some pulmonary irritant other than coal dust. Accordingly, the causation presumption under 20 C.F.R. § 718.203 (b) has not been rebutted and I find Mr. Henley's complicated pneumoconiosis is due to his coal mine employment.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. Having invoked the 20 C.F.R. § 718.304 irrebuttable presumption, and causation presumption 20 C.F.R. §718.203 (b), Mr. Henley has also established that he is totally disabled due to coal workers' pneumoconiosis. Having established all four requisites of entitlement, Mr. Henley is entitled to disability benefits under the Act.

Date of Entitlement

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the

[31] *See also Parsons v. Wolf Creek Colleries*, 23, B.L.R. 1-_____, BRB NO. 02-0188 BLA (Sept. 30, 2004) (en banc) (the potential for progressivity and latency of pneumoconiosis is inherent in every case) and *Workman v Eastern Assoc. Coal Corp*., BRB No. 02-0727 BLA (Aug. 19, 2004) (order on recon.) (en banc).

claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Even though some of the evidence in Mr. Henley's previous claim suggested the presence of complicated pneumoconiosis, that evidence was inconclusive. Mr. Henley did not present any medical evidence for the period between 1996 and early 2002. The first definitive evidence of complicated pneumoconiosis is the chest x-ray taken in February 2002 during Mr. Henley's treatment for shortness of breath. In the absence of any other post-1996 medical evidence, I find the February 2002 radiographic study, which predates the July 2002 filing date of Mr. Henley's second claim, establishes that by February 2002 he was totally disabled due to coal workers' pneumoconiosis. As a result, Mr. Henley's black lung disability benefits are payable beginning February 1, 2002.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205. In light of my preliminary determinations, I find that Mrs. Charlotte Henley is a qualified spouse, meeting the regulatory requirements for spousal augmentation of Mr. Henley's black lung disability benefits.

CONCLUSIONS

Since Mr. Henley last worked as a coal miner within the meaning of the Act and regulations for more than one year with Cowin and Company, that employer is the responsible operator.

Based on the presence of large opacities in the preponderance of the chest x-ray evidence, and in the absence of sufficient contrary evidence showing a non-coal dust related cause, Mr. Henley has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. That invocation also establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3), which permits re-adjudication of Mr. Henley's entitlement to benefits. Finally, through the presumption in 20 C.F.R. § 718.203 (b), with at least 18 years of coal mine employment, Mr. Henley is also able to establish that his pneumoconiosis was due to his coal mine employment. Having proven that he is totally disabled due to coal workers' pneumoconiosis, Mr. Henley is entitled to black lung disability benefits under the Act. As a result, his present claim must be approved. The date of entitlement is February 1, 2002, with benefits augmented for his spouse, Mrs. Charlotte Henley.

ATTORNEY FEES

Counsel for the Claimant has thirty days from receipt of this decision to submit an additional application for attorney fees related to this case in accordance with 20 C.F.R. § 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including Claimant. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with the claim.

ORDER

The claim of MR. DONALD R. HENLEY for benefits under the Act is **GRANTED**. COWIN AND COMPANY, INC. is ordered to:

1. Pay Mr. Donald R. Henley all benefits to which he is entitled under the Act and Regulations. Benefits shall commence February 1, 2002, augmented for his spouse Mrs. Charlotte Henley.

2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602 (a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. Donald Henley;

3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and

4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608 (b).

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: May 26, 2004
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties

Certification:

Randolph J. Forehand, MD

Certified by the American Board of Allergy and Immunology in:

Pediatrics, Allergy and Immunology

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Attachment No. 2

American Board of Medical Specialties

Certification:

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Attachment No. 3

American Board of Medical Specialties

Certification:

David Soike, MD

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